

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X3) DATE SURVEY COMPLETED 02/22/2019
NAME OF PROVIDER OR SUPPLIER SANDY PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - INITIAL COMMENTS

An unannounced licensure/complaint survey, CCR# 2019002111 was commenced on and concluded on at Sandy Pines, Residential Treatment Center For Children And Adolescents facility, License Number 52.

Two of four allegations were substantiated.

The facility had deficiencies at the time of the investigation.

0083 - Hlth/Med/EmerMed/Psych Srvs Illness/Incident - 65E-9.006(7)(d), F.A.C.

Based on record review and interview, the RTC (Residential Treatment Facility For Children And Adolescents) failed to immediately notify the resident's parent of a arm for 1 of 3 sampled residents reviewed (Resident #1).

The findings included:

A review of Resident #1 file reveals Resident #1 was complaining of their arm "hurting" on at 1:55 AM. On Sunday,, Resident #1's parent informed the RTC's staff that the resident had limited range of motion in their arm. Further review reveals the RTC's Nurse notified the physician and Resident #1's name was placed on the "medical board."

Continued review reveals that on Monday,, the resident's parent called the RTC stating that the resident cannot move their arm. Further review reveals that upon assessment, Resident #1 was not able to straighten their arm.

Tuesday,, the Advanced Registered Nurse Practitioner came to the RTC to assess Resident #1 and determined the resident needed to have a portable The results of which documented the resident had a right upper arm and the resident would be sent to the Emergency Room the following day, Wednesday,

There was no evidence of documentation that the resident's parent was notified on Tuesday, that an was ordered, the results of the, and that the resident would be sent to the Emergency Room the following day, Wednesday, Continued review reveals the resident's parent was notified the next day, Wednesday, at 8:11 AM.

During an interview on at 2:51 PM, Staff "G" states she wrote the "note" on at 8:19 AM for Staff "H" because she is a night nurse, it was getting late for her to leave and stated she notified Resident #1's parent of the and that the resident going to the Emergency Room that morning.

0122 - Staff Composition - Behav Analyst - 65E-9.007(3)(f), F.A.C.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X3) DATE SURVEY COMPLETED 02/22/2019
---------------------------	---	---

NAME OF PROVIDER OR SUPPLIER SANDY PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469
--	--

SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on record review and interview, the Residential Treatment Facility For Children And Adolescents failed to provide Behavioral Analysis services for 1 of 3 sampled residents (Resident #1).

The findings included:

Review of Resident #1's record, on _____, documents a physician's order, dated _____, for a referral for Behavioral Analysis services. Further review of the resident's record reveals no evidence of documentation of the resident receiving Behavioral Analysis services.

During an interview on _____ at 2:51 PM, the Director of Clinical Services stated the resident can be referred to our Behavioral Analyst who will do a "functional behavioral assessment" and based on that a behavior protocol is initiated. During the interview on _____ at 2:51 PM, the Director of Clinical Services was asked for evidence of documentation of Resident #1's Behavioral Analysis and she stated, "The Behavioral Analyst stepped into a Clinical Manager role on _____ and all referrals were paused. We just hired a new Behavioral Analyst this week." During the interview on _____ at 2:51 PM, the Director of Clinical Services reviewed the physician's order for Behavioral Analysis services for Resident #1, to ascertain if it was done, acknowledged that it was not done and stated, "Resident #1 will be put on a "wait list."

0154 - Treatment Plan - Monthly Provider Review - 65E-9.009(5), F.A.C.

Based on record review and interview, the Residential Treatment Facility For Children And Adolescents failed to follow the Plan of Treatment to conduct a Behavioral Analysis 1 of 3 sampled residents. (Resident #1).

The findings included:

Review of Resident #1's record, on _____, documents a physician's order, dated _____, for a referral for Behavioral Analysis services. Further review of the resident's record reveals no evidence of documentation of the resident receiving Behavioral Analysis services.

During an interview on _____ at 2:51 PM, the Director of Clinical Services stated the resident can be referred to our Behavioral Analyst who will do a "functional behavioral assessment" and based on that a behavior protocol is initiated. During the interview on _____ at 2:51 PM, the Director of Clinical Services was asked for evidence of documentation of Resident #1's Behavioral Analysis and she stated, "The Behavioral Analyst stepped into a Clinical Manager role on _____ and all referrals were paused. We just hired a new Behavioral Analyst this week." During the interview on _____ at 2:51 PM, the Director of Clinical Services reviewed the physician's order for Behavioral Analysis services for Resident #1, to ascertain if it was done, acknowledged that it was not done and stated, "Resident #1 will be put on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X3) DATE SURVEY COMPLETED 02/22/2019
NAME OF PROVIDER OR SUPPLIER SANDY PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
<p>a "wait list."</p> <p>0180 - Children's Rights - 65E-9.012(1), F.A.C.</p> <p>Based on record review, interview and observation, the Residential Treatment Facility For Children And Adolescents failed to ensure that their residents were protected from any , , for 1 of 3 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Review of Resident #1's record reveals Resident #1 was admitted to the facility on , , with diagnoses requiring facility admittance. Review of Resident #1's record documentation that reveals on , , at 7:00 PM, Resident #1 was involved in an altercation with peers and staff.</p> <p>A "camera review," by the Surveyor and the Director of Nursing on , , at 2:00 PM, documents an incident in the playroom on , , at 6:56 PM; Resident #1 was observed on the camera review, in the playroom with several other residents, involved in an altercation between two other residents. Staff "C" is observed, "grabbing" one of Resident #1's arms and pulled the resident away from the area. Staff "A" is observed stepping between two residents and staff are observed attempting to control the residents. The camera view only reveals staff in the corner of the room trying to control residents and does not reveal any other residents. Staff "A" is observed "grabbing" the , of Resident #1's shirt by their , while forcing the resident to walk forward, pushing the resident towards the door.</p> <p>Review of the "Multidisciplinary Progress Notes," reveal evidence of documentation that on , , at 01:55 AM, Resident #1 came to the Nurse's Station complaining of their right , hurting and after assessing that the resident had full range of motion of the arm, was able to move it with no redness, , or , , the nurse gave the resident , , 325 milligrams and an ice compress for comfort.</p> <p>Further review reveals that on , , seven days after the resident complained of arm , , Resident #1's parent was in the facility, stated, to a Nurse that the resident's arm was hurting and the resident could not move it. Further review reveals the Nurse documents Resident #1's arm is "slightly , , " with "limited range of motion," contacted the Medical Doctor's office and the resident was placed on the "Medical Board to be seen by the Medical Staff.</p> <p>Review reveals on , , Resident's #1's parent contacted the Residential Treatment Facility For Children And Adolescents, wanting to know if anything had been done regarding the resident's arm and felt that it could be broken. The Nurse contacted the physician for a portable , to be done. On , , at 6:50 PM, an Advanced Registered Nurse Practitioner came to the Residential Treatment Facility For Children And Adolescents to evaluate Resident #1's arm and requested an , to be completed. The results of the , , documents Resident #1 has a , . Continued review reveals</p>		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X3) DATE SURVEY COMPLETED 02/22/2019
NAME OF PROVIDER OR SUPPLIER SANDY PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
<p>the resident was not sent to the Emergency Room until at 9:30 AM.</p> <p>0191 - / - No Harm/Injury - 65E-9.013(1)(b), F.A.C.</p> <p>Based on record review, observation and interview the Residential Treatment Facility for Children and Adolescents failed to ensure the safety of the resident during a for 1 of 3 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Review of Resident #1's record reveals Resident #1 was admitted to the facility on with diagnoses requiring facility admittance. Review of Resident #1's record documentation that reveals on at 7:00 PM, Resident #1 was involved in an altercation with peers and staff resulting in a A "camera review," by the Surveyor and the Director of Nursing on at 2:00 PM, documents an incident in the playroom on at 6:56 PM; Resident #1 was observed on the camera review, in the playroom with several other residents, involved in an altercation between two other residents. Staff "C" is observed, "grabbing" one of Resident #1's arms and pulled the resident away from the area. Staff "A" is observed stepping between two residents and staff are observed attempting to control the residents. The camera view only reveals staff in the corner of the room trying to control residents and does not reveal any other residents. Staff "A" is observed "grabbing" the of Resident #1's shirt by their while forcing the resident to walk forward, pushing the resident towards the door.</p> <p>Review of the "Multidisciplinary Progress Notes," reveal evidence of documentation that on at 01:55 AM, Resident #1 came to the Nurse's Station complaining of their right hurting and after assessing that the resident had full range of motion of the arm, was able to move it with no redness, or the nurse gave the resident and an ice compress for comfort.</p> <p>Further review reveals that on seven days after the resident complained of arm Resident #1's parent was in the facility, stated, to a Nurse that the resident's arm was hurting and the resident could not move it. Further review reveals the Nurse documents Resident #1's arm is "slightly" with "limited range of motion," contacted the Medical Doctor's office and the resident was placed on the "Medical Board to be seen by the Medical Staff.</p> <p>Review reveals on Resident's #1's parent contacted the Residential Treatment Facility For Children And Adolescents, regarding the resident's arm. The Nurse contacted the physician for a portable to be done. On at 6:50 PM, an Advanced Registered Nurse Practitioner came to the Residential Treatment Facility For Children And Adolescents to evaluate Resident #1's arm and requested an to be completed. The results of the documents Resident #1 has a</p>		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X3) DATE SURVEY COMPLETED 02/22/2019
NAME OF PROVIDER OR SUPPLIER SANDY PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Continued review reveals the resident was not sent to the Emergency Room until at 9:30 AM. Observation, on at 2:10 PM reveals Resident #1 is wearing a ".....," covering their upper and lower right arm. During an interview on at 3:26 PM, Staff "C" stated, "We were not taught a certain method when the residents are fighting," grabbed one of the resident's arms and pulled the resident to the side. "I wouldn't use SAMA (Satori Alternatives to Managing Aggression) technique; in that instance I can't restrain more than one resident. I would call for help. I stayed in the playroom and two other staff removed the residents."

0207 - / - Team Review - 65E-9.013(3)(h), F.A.C.

Based on record review and interview, the Residential Treatment Facility for Children and Adolescents failed to review the / that the resident received review no less than two times per month for 1 of 3 sampled residents reviewed (Resident #1).

The findings included:

Review, on and of Resident #1's record reveals documentation of "Weekly Team Meetings" with a section for "..... and" and "intervention and changes to treatment plan due to/.....". Further review reveals four of the "Weekly Team Meetings" with no evidence of documentation that addresses or documents 5 of 8 Resident #1 received. The "Weekly Team Meeting" documentation for Resident #1's last on is not in the resident's record. The "Weekly Team Meeting" on for the reported period - does not document a on The "Weekly Team Meeting" on for the reported period - does not document a on and The "Weekly Team Meeting" on for the reported period - does not document a on and the "Weekly Team Meeting" on for the reported period - does not document a and on The "Weekly Team Meeting" for a dated is not in resident's record. During an interview on at 2:51 PM, Director of Clinical Services states the psychiatrist, the nurse, the and if necessary, the staff, via the charge nurse, would be involved in the "Weekly Team Meetings. We review it weekly and document the and on the "Weekly Team Meeting" form, we review it monthly as well and what interventions were tried." During a telephone interview on at 4:28 PM, Resident #1's states, "Weekly Team Meetings" are completed by myself, the physician and nurse who meet about how the resident is doing and talk about how they are doing in and school. I usually fill out the form; we do review and but what happens is the physician types up his note as well. He dictates his

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/19/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X3) DATE SURVEY COMPLETED 02/22/2019
NAME OF PROVIDER OR SUPPLIER SANDY PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
<p>note and it's based on clinical recommendation or medication changes or discussion, if I make changes. What changes with the resident is different interventions, behavioral protocols; we did a referral for a Functional Behavioral Questionnaire. The Behavioral Analyst does that. I was not aware that it was written. It was a covering the physician that wrote the order so I wasn't aware of it. That is not a protocol, there is a form and it is not an order."</p> <p>0218 - Post / - Debrief With Staff - 65E-9.013(10)(b), F.A.C.</p> <p>Based on record review and interview, the Residential Treatment Facility for Children and Adolescents failed to ensure that a staff debriefing was conducted with all staff involved in a for 1 of 3 sampled residents reviewed for (Resident #1).</p> <p>The findings included:</p> <p>Review of the Residential Treatment Facility for Children and Adolescents' own policy titled, " and " effective , revised on and reviewed , reveals evidence of documentation that within 24 hours post / the staff involved in the intervention and the appropriate members of the treatment team will conduct a debriefing session.</p> <p>Review, on of Resident #1's record, reveals that the resident had a Order on that was initiated at 7:00 PM that ended at 7:01 PM. Further review of the order/record revealed 1 of 2 staff members, Staff E, identified in the did not participate in the debriefing for staff.</p> <p>During an interview on at 10:44 AM, Staff "E" stated he does not recall if he debriefed with other staff members after the incident as he is not assigned to that Unit, where Resident #1 was but intervened when he saw the residents "acting up."</p>		